Health Care Reforms in the United States: Initiatives at the State Level

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HEALTH CARE REFORMS IN THE UNITED STATES: INITIATIVES AT THE STATE LEVEL

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HEALTH CARE IN THE U.S.

Most Canadians, when we consider the problems of our own health care system, are at least vaguely aware of the crisis faced by the American system. The latter system suffers from a combination of high costs, problems in access for many Americans and poor health outcomes.

- The U.S. spends 13.2% of its Gross Domestic Product on health care, a far higher proportion than any other developed country.[1]

- One-fifth of the American population under 65 have no health care insurance, a proportion which has increased dramatically since 1980; in 1993, over 41 million Americans had no insurance.[2]

- Retired people and those on social assistance are covered by federal programs (Medicare and Medicaid respectively), but most Americans rely on their employer to provide health insurance. However, fewer employers are providing insurance. Thus, over half of the 41 million people without insurance in 1993 were in families headed by at least one person with a full-time, full-year job.[3]

- The effects of limited availability of preventive care are seen in poorer U.S. health outcomes: the U.S. has the highest rate of infant mortality of the developed countries, and the lowest male life expectancy.[4]

- Among Canadian, American and British people surveyed for one study, Americans are the least happy with their health care system; 89% in one survey think it needs fundamental change.[5]

The reasons for this situation are not entirely clear. Most commentators agree that some of the reasons for the high costs are an over-reliance on high-tech medicine and specialist practitioners, fragmentation of the consumer market for insurance (discussed below), and high administrative costs (close to one-quarter of total health spending).[6] High health insurance premiums for small businesses have made it harder to insure employees, even when employers are willing to do so. Of course, the U.S. is also the only developed country not to have some form of public health insurance available to all its citizens.

Whatever the broader social and environmental factors, inequality of access to health care contributes to the poorer overall health of Americans as compared to citizens of other affluent countries.

Americans who have no health insurance are not necessarily denied medical care; hospitals spend more than eight billion dollars a year providing emergency and charity care.[7] However, it does mean that many people cannot afford routine and preventive care, with potentially devastating implications. A recent study demonstrated that women without insurance or with public insurance (Medicaid) were more likely to be diagnosed at a later stage of breast cancer, and were much more likely to die of the disease than women who had private insurance.[8]

President Clinton was elected on a platform promising comprehensive health system reform and universal coverage. The 1,300-page *Health Security Act*, which resulted from an extensive process of hearings and expert advice, suggested retaining a competitive private health insurance market and employer coverage, features shared by the state reforms described in this paper. However, with the failure of the Clinton proposal and a number of rival proposals for health insurance reform in fall 1994, innovative state reform proposals are likely to receive renewed attention.

This paper opens with a description of the health system in Hawaii, which offers universal coverage, lower costs than elsewhere in the U.S. and good health outcomes. However, political constraints in the U.S. probably make the Hawaiian model, like the Canadian system, not viable for the rest of the country. The paper also deals with ongoing reforms in Oregon in some detail, since they have received extensive media attention. Oregon has expanded the number of people with health insurance to include working poor people in the state, but has specified the range of treatments that will be covered. This program, launched in 1994, is likely to continue in that state but not to be adopted elsewhere until its effects are clear. Finally, the paper deals with reform proposals in three other states (Minnesota, Florida and Vermont), as typical of the more incremental reforms likely to be pursued at the state level in the near future.

HAWAII

Existing System

Almost all residents of Hawaii have health insurance, provided by their employer, the federal government or the state government. Since 1974, the state has mandated that all employers have to provide health insurance for employees who work more than 20 hours/week;

employers must pay at least half the premiums, and employees cannot pay more than 1.5% of wages as their share.[9] Costs are kept down for small business by "community rating," by which premiums are set for a whole neighbourhood, rather than based on the health histories of the employees. As a result, the state's health insurance program, called SHIP, is residual only. It was implemented in 1990 and covers poor, mostly unemployed people, approximately 5% of the state's population.[10] As elsewhere, people on welfare and people over 65 are covered by Medicaid and Medicare respectively.

The success of Hawaii's system is obvious and measurable:

- it has the lowest death rate of the states;[11]
- health insurance premiums are lower than in other states; and
- it has the lowest infant mortality of the states.[12]

Of course, the particular ethnic mix, excellent climate, and lifestyle of the islands have a good deal to do with some of these outcomes.[13] Nonetheless, the low premiums are one measurable record of successful cost control; another measure shows that total health costs as a proportion of GDP in Hawaii are more in line with Canada or European countries and much lower than other states.[14] More important, lack of access to prenatal care is generally agreed to be a factor in high infant mortality in the U.S.; Hawaii's experience suggests that this situation can be improved.[15]

Single Payer System

Like Canada, and unlike most other states, Hawaii until very recently had only one purchaser of health services, Hawaii Medical Services Association (HMSA), which is the local affiliate of Blue Cross. There is now one other insurance company in the state, Kaiser Permanente; some 20% of Hawaiians are enrolled in this Health Maintenance Organization (HMO), a prepaid plan in which each enrolled person pays a given amount of money for all medical care.[16] Canadian and European experience suggests that one or a few powerful payers are much more effective at controlling the costs, particularly the costs of physicians and hospitals, than the fragmented U.S. insurance market.

It is also agreed by observers that the relatively high rate of unionization in Hawaii has been important to the development of the health system in Hawaii. Unions across the United States have been

closely involved in negotiating health insurance benefits for their members. Both the "plantation" agriculture (tracts of land farmed by large businesses) and the public sector in Hawaii have been heavily unionized since the Second World War. Both sectors have historically been involved in state politics and have supported a relatively interventionist state government.[17]

Employer Provision of Health Insurance

The basic approach taken by Hawaii to insuring most residents of the state is typical of the U.S. (and indeed several European countries, including Germany). Health insurance is seen as a benefit of employment, and the role of the state is to ensure that employers provide that benefit. They have left most cost control initiatives in the hands of the private insurers, as other states do, and have left coverage of dependents as a matter to be negotiated in the employment contract. This is ensured by the strength of unionization on the islands, as noted above.

In general, large businesses in the U.S. are relatively supportive of a public role in health insurance, while small business is strongly resistant, especially to compulsory employer provision. Essentially, this is because large businesses tend to provide insurance as a benefit, and can control costs by using the leverage provided by a large group of employees in negotiating with insurers or providers. Small businesses, on the other hand, do not have this leverage, and are relatively powerless to negotiate premiums for their employees. However, the power of the two insurers on the island, their ability to control costs, and their obligation to charge the same premiums to all businesses in a community, have resolved some of these issues for Hawaiian businesses. Providing health insurance is treated as a normal cost of doing business in the state. Premiums are less costly than in other states, whereas most other costs of living and doing business on the islands are higher.[18]

Another relic of the plantation economy of the past is a high use of outpatient services, which were traditionally provided in employer-provided clinics.[19] This is unusual in the U.S., where emergency wards in inner-city hospitals are used as a "safety-valve," a place where uninsured people can receive charitable emergency health care. Hospitals then tend to treat paying patients very intensively, doing as many procedures as possible that can be billed to their insurance companies and otherwise using paying patients to subsidize the unpaid care they provide. As a result, on an international comparison, patients

in the U.S. tend to have the shortest, but at the same time most expensive, hospital stays in the world.[20]

Hawaii is not immune to these problems, but is controlling the number of hospitals built, and is trying to control costs in existing facilities.[21] The state also has a bad record in providing mental health care, ranking fiftieth of the fifty states in this area in several recent years.[22] Finally, native Hawaiians have significantly poorer health than other residents of the islands, an issue which has started to be addressed in the 1988 federal law, the *Native Hawaiian Health Care Act*.

Proposals for Change

The state applied in 1993 for a Medicaid waiver from the federal government, to allow it to combine the funds for Medicaid with the SHIP fund (which serves people who are not receiving welfare). This would make the existing system less complicated, in that all low-income people, some 90,000 residents of Hawaii, would be covered by the same program, to be called HealthQUEST. It would provide diagnostic services to all children in the state and would improve coverage of mental health services.[23] The state also applied for exemptions from federal law to make it easier to insure employees' dependants. Whatever happens to these initiatives, Hawaii, like Canada, has managed to provide health insurance to all of its residents, while controlling costs.

OREGON

Oregon has approached the problem of providing universal coverage and controlling the costs of publicly-provided insurance in a very different way. The state's plan for covering its population has received a great deal of attention, mainly because it has been portrayed as a rationing plan. It would probably be more accurate to call it a different kind of rationing approach than that seen elsewhere, though not acknowledged, in the U.S. system: procedure-based rationing, rather than population-based rationing. The Oregon plan covers health care based on the perceived effectiveness of the treatment, rather than the type of health insurance the individual has. Unlike Hawaii, which has had twenty years to deal with the strengths and weaknesses of its approach to the health system, Oregon's plan has only been in

operation since 1994, is not yet fully implemented, and cannot yet be assessed in any comprehensive way.

Proposed System

One of the most interesting aspects of the Oregon plan was the way in which it was developed. A Health Services Commission was established and started its work in September 1989. It developed a list of 709 "condition-treatment pairs" (CT pairs), which were intended to describe all possible medical conditions and their usual treatments. It held 12 public hearings and attended 47 community meetings. It also commissioned a random telephone survey of Oregonians. The public input was intended to establish "social health values;" the priorities people have for health care.[24]

In May 1990 the Commission released a draft "priority list" of CT pairs. They were ordered according to the health priorities Oregonians had expressed and the results of a complicated formula which tried to quantify and calculate the costs, health outcomes and benefits of each procedure. This list was not received very well - some of its rankings violated common sense, such as placing tooth capping just above surgery for ectopic pregnancy.[25] However, advocates of this general approach claimed that at least some of these rankings came about because the Commission concentrated on immediate costs and benefits, and did not extend its analyses of costs and health outcomes far enough into the future.[26] In response to criticism, the Commission abandoned considerations of cost in giving the CT pairs priority rankings and instead grouped them into categories based on benefit to the individual and to society, taking into consideration the results of the public consultation in developing categories.[27]

The revised list of 709 condition-treatment pairs ranked in order of priority was released in February 1991. Detailed cost estimates for all the pairs were made, to allow the legislature to draw a line at what procedures it would pay for in the new system. This line was drawn at number 587; procedures under that pair would not be covered by public insurance, though private insurance was expected to get into the market to provide procedures and services not covered by the state. Under the legislation, the list of covered services is to be reviewed every two years; both where the line is drawn and the position of particular condition-treatment pairs can be changed in this review. The Commission can also be contacted by any citizen who might wish to disagree with a given ranking.

List of Covered Procedures

The 709 condition-treatment pairs were divided into 17 categories, which were in turn described as "essential" (for example, treating fatal conditions and providing preventive care, comfort care, and reproductive services, so important to both society and the individual), "very important," and "valuable to certain individuals." It should also be noted that all diagnostic services are covered; Canadian experience suggests that these services can be a significant source of increased costs.[28] Of 366 services described as "essential," eight are not covered, including liver transplant for alcoholic cirrhosis of the liver. Fifty-one of the 275 "very important" services are not covered, including medical therapies for chronic prostatitis and cystitis and breast reconstruction after mastectomy. However, sixty-three of the 68 services which are characterized as only being "valuable to certain individuals" are not covered.[29]

People Covered

As noted above, many poor people do not have access to health insurance under the American system. However, under the Oregon Health Plan as it was originally envisioned, all people under the poverty line would be covered under Medicaid, whether they are receiving AFDC (federally funded social assistance) or not, and all employed people would be covered by their employers (see below).

Newly insured people under the plan would be enrolled in HMOs or a "primary care case manager program." Oregon has a tradition of fairly good coverage by HMOs. The case manager program would contract with physicians and nurse practitioners to provide all primary care on a fee-for-service basis, to make referrals for specialist care and to monitor inpatient care for Medicaid clients.[30] However, the federal Office of Technology Assessment was asked to examine the Oregon proposal, and questioned whether managed care could be implemented as rapidly as the state believed it could be.[31]

The state proposed a carrot and stick approach to mandating employer-provided health insurance, giving businesses tax incentives to insure their employees in the early stages of the plan, and forcing them to do so later. Senate Bill 935 requires all employers to provide at least the benefit package provided by the state to all permanent employees and their families. Employers are given enriched tax credits if they insure their employees early; the credits are then gradually phased out; and employers would eventually have to make monthly payments into a state-run insurance pool (which will also cover so-called "uninsurable"

people -- those with a medical condition requiring expensive care who are therefore a poor risk for insurance) to cover their employees. However, the deadlines for this "pay or play" portion of the changes was moved back to 1997-98; with the election of a Republican Legislature in 1994, they may be dropped altogether.

Federal Waiver

A legal opinion from the White House argued that the Oregon plan violated the *Americans with Disabilities Act*, a centrepiece of the Bush Administration's social policy, by considering "quality of life" in ranking treatments, which was thought to systematically undervalue the right of people with disabilities to treatment. The President refused the waiver the state needed to redistribute its Medicaid funds according to its plan.[32] However, the Clinton administration decided in March 1993 to grant the necessary Medicaid waiver for a five-year term, with some conditions responding to complaints from disability groups. These 29 specific conditions on the waiver address concerns of disabled groups about the rankings of specific procedures, ask that the state consider whether treatment for infertility, a disability, should be covered, and require the state to set up a telephone line and appeal procedure to allow providers to argue for providing treatments not in the "basic package."[33] The conditions also commit the state to providing the basic package of 568 condition-treatment pairs for the five years of the project. Any changes to this list ("drawing the line" higher than 569 on the list of condition-treatment pairs) can only be done with the approval of the federal Department.[34]

Implementation

The first phase of the plan came into force February 1, 1994. The need for it is demonstrated by the number of enrolees – 103,000 people had enrolled by January 1995, which exceeded projections by 27%.[35] An early success for the program came when emergency room visits, the main route to care for the uninsured, fell by 5 to 10% in 1994 from the previous year.[36] Bipartisan consensus on the Plan is suggested by the fact that the Republicans, who now control both the House and Senate in the state, are opposing only the employer mandate, not the expanded coverage of people or limited coverage of procedures.

MINNESOTA

The MinnesotaCare health plan is a program which provides incremental improvements to coverage for specific groups in the state, but concentrates on cost control within the system as a first step to affordable, wider coverage of the population. Its goals were limited in the first place, and have been only partly reached.

The law implementing MinnesotaCare was introduced and passed in only six weeks, though a commission had studied the issues for three years and a similar bill had come close to passage.[37] However, the rapid passage of the bill meant that Minnesotans have been in the position of reacting to a *fait accompli*, and did not have the extensive public input of Oregon residents. Perhaps partly as a result of this, takeup of MinnesotaCare has been lower than expected, and in fact the number of uninsured people in Minnesota has increased over the last four years. However, the rate of increase of the uninsured is slower than elsewhere in the U.S., and advocates claim that MinnesotaCare has played a role in this slowing.[38]

Approach

In the area of cost control, the law established: a Minnesota Health Care Commission mandated to reduce health care inflation; regional coordinating boards to recommend on specific issues regarding provider agreements, acquisition of new technology, etc.; and anti-trust protection for groups working to reduce costs. For small employers, the law mandates insurers to offer low-cost plans with specified minimum benefits and maximum deductibles, and keeps insurance premiums within specified ranges. Similarly, individual premiums cannot be raised based on experience rating (i.e. if the individual gets sick) and otherwise prevents various types of cherry-picking (insuring only the most healthy people and avoiding people who are likely to claim benefits under their policies). Finally, the law established MinnesotaCare itself.

This is a plan under which families and individuals, whose incomes are under 275% of the poverty line, are eligible for services that were already available to low-income children under the Children's Health Plan. These services include physician and dentist visits, diagnostic and preventive services, home care, outpatient and inpatient services and most prescription drugs. Co-payments are made for glasses, prescriptions and hospital care, the latter up to a maximum of $1,000

per individual and $3,000 per family.[39] Eligible residents of Minnesota have to apply for coverage, and pay a sliding-scale premium based on their income. The premium is subsidized by the state, funded by a 2% tax on health care providers and a cigarette tax.

Implementation

The plan was available: starting July 1, 1992, to the families of children already eligible for the Children's Health Plan; from January 1, 1993, to families with children with incomes up to 275% of the poverty line; and from January 1, 1994, to single people and families without children with incomes up to 275% of the poverty line. By June 1993, the program was serving 53,000 people, out of an estimated pool of some 170,000.[40]

FLORIDA

Florida, not a state noted for innovative policy initiatives, has had a plan for health insurance reform since 1992. This is probably a result of the fact that the state has an unusually large number of people, some 23% of the population, with no insurance.[41] Even more than Minnesota, though, which is subsidizing access to a public plan, Florida's reforms are directed at improving *access* to health insurance, rather than actually providing insurance.

Like other states, Florida is emphasizing cost control within a basically unchanged market of private health insurance. It is making insurance more affordable to small businesses by creating Community Health Purchasing Alliances (CHPAs), essentially wider pools of insurance purchasers, to give small businesses more leverage with insurance companies. State employees and Medicaid recipients are in the same pool. The CHPA also provides information on the price and effectiveness of various insurance plans to employers, to help them choose an appropriate plan for their employees. Ideally, the competition created in this situation will lower prices, or at least slow increases. Employers will at some point be required to offer insurance covering a basic package of health benefits to their employees; as in Oregon, however, this employer mandate is conditional on cost containment, and has not yet been implemented.[42]

1994 legislative proposals continued to emphasize cost control, but took more steps towards actually increasing coverage. Medicaid recipients were to be moved into managed care, and the money saved

was to be used to subsidize health insurance for low-income people who do not receive insurance from their employers and are not eligible for Medicaid. These changes to Medicaid required a waiver from the federal Department of Health and Human Services, which was granted in September 1994.[43] Though the legislation was not passed in the 1994 session, the returned governor, Lawton Chiles, has announced that he will seek the same changes in the new legislature.[44]

In 1994, however, the CHPAs were able to negotiate costs ranging from 9.5% to 40% below what the same plan would cost private insurers, and 2,000 businesses had signed on as of September 1994.[45] This voluntary approach, emphasizing control over health costs and avoiding interference with the private market, is almost certain to continue given the Clinton administration's defeat over national health insurance, a failure in which the insurance lobby is agreed to have played a major part.

VERMONT

Vermont's proposals for change shifted over the course of 1994 from relatively radical to carefully incremental, and may, like President Clinton's, disappear altogether. This happened in spite of a small population, a relatively small number of insurers (as in Hawaii), and a strong lobby for a Canadian-type system.

In 1991, Vermont passed legislation requiring community rating by insurance companies. In 1992, it passed legislation creating a Health Care Authority, which would ultimately control total allocations to the health care system, and a purchasing pool, which would ultimately cover all Vermonters (including people on Medicaid, Medicare, and those purchasing insurance privately or through employers). This large pool of purchasers could then acquire different insurance packages, presumably with different premium, deductible and copayment elements. The legislature asked for a report from the Health Care Authority on two payment methods: one with premiums paid by employers and various tax changes to pay for coverage for the unemployed; a second to provide universal coverage on the Canadian model, financed by a payroll tax.[46]

However, these very extensive changes did not pass the state legislature, and the governor has presented plans for incremental improvements in coverage on the model of other states. The Health Care Authority is expected to continue to recommend cost control measures, and health insurance coverage for people earning up to

150% of the poverty line is a goal for 1997. This improvement is to be financed by increased cigarette taxes.[47]

Other States

Some twenty-one states have commissions or other bodies looking at health system reform.[48] A Wyoming commission has recommended higher sin taxes to finance reform; a Washington commission has been mandated to produce legislation by 1995; a single-payer proposal was on the ballot in California in November 1994, though it was defeated by a margin of 73% to 27%. However, all the proposals that have come close to implementation have tinkered at the margins: managed care, strengthening competition in the system, etc. Even Oregon's integration of outcomes research or Minnesota's provider tax do not challenge the basic free market model of providing health care and the patchwork of entitlement programs for those who cannot access the private health insurance market.

Conclusion

It may be that one of the current variety of proposals will produce a model as successful as Hawaii's (though no employer mandate is likely to be allowed by a Republican Congress). The last wave of federal health reforms took place in the mid-1970s, and resulted in an openness to change that allowed the Hawaii experiment to proceed. With the failure of the Clinton proposal, it can only be hoped that federal action on a national program will not be dormant for another twenty years, particularly since none of the state reforms currently proceeding seem likely to be as successful as Hawaii's were. Meanwhile, the number of Americans without any health insurance, or with inadequate coverage, continues to grow.

NOTES

[1] U.S. Department of Health and Human Services, Public Health Service, *Health United States 1993* (Hyattsville Md.: Public Health Service, 1994), p. 42.

[2] Ibid., p. 49; and *BNA's Health Care Policy Report (HCPR)*, 3:5 (30 January 1995): 178.

[3] *HCPR* 3:5 (30 January 1995): 178.

[4] John Labate, "The World Economy in Charts," *Fortune*, 27 July 1992.

[5] Robert J. Blendon and Humphrey Taylor, "Views on Health Care: Public Opinion in Three Nations," *Health Affairs* (Spring 1989): 151.

[6] United States, Congress, House, Committee on Ways and Means, Subcommittee on Health, *Health Care Reform - Volume IV*, 103rd. Cong., 1st. sess., 8 June 1993, statement of Robert D. Reischauer, Ph.D., Director, Congressional Budget Office, p. 302.

[7] Julia Silver and T. Peterson, "Hospital, Heal Thyself," *Business Week*, no. 3175 (27 August 1990): 66.

[8] "Breast Cancer Takes Bigger Toll Among Poor," *Wall Street Journal*, 19 June 1992, p. B1.

[9] Marilyn Moon and John Holahan, "Can States Take the Lead in Health Care Reform?," *Journal of the American Medical Association (JAMA)* 268: 12 (23/30 September 1992): 1589.

[10] Paul Cotton, "`Basic Benefits' Have Many Variations, Tend to Become Political Issues," *JAMA* 268: 16 (28 October 1992): 2140.

[11] "Places to Live," *American Health* (March 1992), p. 63.

[12] Michael Dukakis, "The States and Health Care Reform," *New England Journal of Medicine* 327:15 (8 October 1992): 1090.

[13] Deane Neubauer, "Hawaii: The Health State," in *Health Policy Reform in America*, Howard M. Leichter ed. (Armonk, N.Y.: M.E. Sharpe, Inc., 1992), p. 148.

[14] Richard V. Stenson, "Comparison of health expenditures in U.S. and Hawaii economies," *Hawaii Medical Journal* 51:1 (January 1992): 14.

[15] Saundra K. Schneider, "Improving Maternal and Child Health Care," in *Health Policy Reform in America*, p. 51.

[16] Ideally, such an arrangement removes the economic incentive for providers to over-

treat, though some critics claim that it provides an economic incentive for the insurance company to under-treat. Kaiser Permanente is the oldest and agreed to be one of the best HMOs in the U.S.

17 "Hawaii: The Health State," p. 151.

18 "Health Care in Crisis: The Search for Solutions: Does Canada Have the Answers?" *Consumer Reports*, 57:9 (September 1992): 590.

19 Ibid.

20 George Schieber et al., "Health Care Systems in Twenty-Four Countries," *Health Affairs* 10:3 (Fall 1991): Exhibit 4, p. 27; and p. 31.

21 "Does Canada Have the Answer?" p. 590.

22 "Hawaii: The Health State," p. 163.

23 Testimony of Peter Sybinsky, Hawaii State Department of Health, in *Health Care Reform - Volume IV*, pp. 641-649.

24 Oregon Health Services Commission, *The Oregon Health Plan*, Information Package (n.p., n.d.), p. 10.

25 David C. Hadorn, "Setting Health Care Priorities in Oregon," *JAMA* 265:17 (1 May 1991): 2219.

26 David Eddy, "Oregon's Methods: Did Cost-effectiveness Analysis Fail?" *JAMA* 266:15 (16 October 1991): 2135-2141.

27 Ibid.; and Harvey Kelvi et al., "Prioritization of Health Care Services," *Archives of Internal Medicine* 151 (May 1991): 912-916.

28 This was pointed out by Sen. Albert Gore, in hearings on the Plan. United States, Congress, House, Committee on Energy and Commerce, Subcommittee on Health and the Environment, *Oregon Medicaid Rationing Experiment*, 102nd Cong., 1st sess., 16 September 1991, p. 56.

29 Robert Steinbrook and Bernard Lo, "The Oregon Medicaid Demonstration Project," *New England Journal of Medicine* 326:5 (30 January 1992): 341.

30 *Oregon Medicaid Rationing Experiment*, pp. 201-202.

31 United States, General Accounting Office, Report to the Chairman, Subcommittee on Health and the Environment, Committee on Energy and Commerce, House of Representatives, *Medicaid: Oregon's Managed Care Program and Implications for Expansion* (Washington: The Office, 1992), pp. 3-5.

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[33] Alan K. Ota, "Oregon health plan approved," *Oregonian*, 20 March 1993, p. A1.

[34] Transcript of news conference with Donna Shalala, Secretary of Health and Human Services, HHS Auditorium, 19 March 1993.

[35] *HCPR* 2:32 (8 August 1994): 1436; and *HCPR* 3:2 (9 January 1995): 49.

[36] *HCPR* 2:41 (17 October 1994): 1766.

[37] Barbara Yawn et al., "MinnesotaCare (HealthRight): Myths and Miracles," *JAMA* 269:4 (27 January 1993): 511.

[38] *HCPR* 2:42 (24 October 1994): 1799.

[39] All information on covered services from Randall Chun, "The MinnesotaCare Health Plan," *House Research: Information Brief* (n.p.: Research Department, Minnesota House of Representatives, July 1993), p. 5.

[40] Statement of Mary Jo O'Brien, Deputy Commissioner, Minnesota Department of Health, in *Health Care Reform - Volume IV*, p. 673.

[41] *HCPR* 3:5 (30 January 1995): 161.

[42] National Governors' Association, *State Progress in Health Care Reform, 1992* (Washington: Centre for Policy Research, The Association, 1993), p. 33.

[43] *HCPR* 2:37 (19 September 1994): 1621-1622.

[44] *HCPR* 3:5 (30 January 1995): 161.

[45] *HCPR* 2:37 (19 September 1994): 1621.

[46] Testimony of Anya Rader, Deputy Chief of Staff, Vermont Governor's Office, *Health Care Reform - Volume IV*, pp. 684-685.

[47] *HCPR* 3:1 (2 January 1995): 18-19.

[48] Members of an *ad hoc* group lobbying the federal government for ERISA changes. *HCPR*, 2:36 (12 September 1994): 1587.